Public Education Employees' Health Insurance Program
Screening Form / HEALTHCARE PROVIDER

TEAM UP FOR HEALTH

GET SCREENED FOR YOUR TEAM!

ADPH Wellness Program
201 Monroe Street, Suite 986
Montgomery, AL 36104
Phone: 1-800-252-1818
Fax: 1-334-206-0385

SECTION 1:
(To Be Completed by Active or Retired Employee or Spouse)

PRINT CLEARLY WITH A BLACK INK PEN.

DARKEN BOXES COMPLETELY.
■ << Not This ■ **<< This** X << Not This

Contract Number:

SSN: (of person being screened) ___ - ___ - ____

☐ **Male** ☐ **Female** ☐ **Contract Holder** ☐ **Spouse**

Screen Date: __ - __ - ____

Birth Date: __ - __ - ____

Daytime Phone Number: ___ - ___ - ____

Last Name:

First Name:

Screening not performed due to: ☐ **Pregnancy** ☐ **Disability**

What best describes your race/ethnicity?

- ☐ White
- ☐ Hispanic / Latino
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ Asian
- ☐ Other
- ☐ Native American / Alaska Native

Do you have (or have you been told you had) any of the following?

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

Do you take any medication for any of the following?

☐ High Cholesterol ☐ High Blood Pressure ☐ Diabetes

SECTION 2: (To Be Completed by Provider)

Blood Pressure: ___ / ___

Total Cholesterol: ___ **mg/dl**

HDL Cholesterol: ___ **mg/dl**

LDL Cholesterol: ___ **mg/dl**

Triglycerides ___ **mg/dl**

Blood Glucose: ___ **mg/dl**

Height: __ **ft** __ **in**

Weight: ___ **lbs**

Waist: ___ . __ **in**

Waist-To-Height Ratio __ **BMI:** __

Has the person being screened used a tobacco product in the last 12 months? ☐ **Yes** ☐ **No**

CLAIMS FILING INSTRUCTIONS FOR COPAYMENT WAIVER: Under the Affordable Care Act, no copayment is required for one annual preventive routine office visit obtained through an in-network provider (not applicable if a diagnosis associated with the visit). File the claim for the member's office visit with BC/BS for PEEHIP Group #14000. Use the appropriate CPT code for the office visit in order to be reimbursed at 100% of the allowable fee. The patient will be responsible for any other applicable copays, such as lab tests. The copay waiver is not allowed at Urgent Care Centers or Emergency Rooms. Please follow the normal billing procedures for subsequent visits.

Healthcare Provider Name (Please Print)

Healthcare Provider Signature

Healthcare Provider Type (Please Print)

Healthcare Provider Address & Phone Number (Please Print)

PEEHIP

ADPH Alabama Department of Publi lth

Please FAX or mail to the **ADPH Wellness Program.**